

## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<b>Facility's Name: Paranada #2</b>	<b>CHAPTER 100.1</b>
<b>Address:</b> <b>16 Hoolaulea Street, Hilo, Hawaii 96720</b>	<b>Inspection Date: April 8, 2019</b>

**THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.**

**YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.**

	<b>RULES (CRITERIA)</b>	<b>PLAN OF CORRECTION</b>	<b>Completion Date</b>
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1) The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><b><u>FINDINGS</u></b> Resident #1, re-admitted on October 24, 2018, no admission assessment.</p>	<p><b>PART 1</b></p> <p><b>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</b></p>	

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (a)(1)  The licensee or primary care giver shall maintain individual records for each resident. On admission, readmission, or transfer of a resident there shall be made available by the licensee or primary care giver for the department's review:</p> <p>Documentation of primary care giver's assessment of resident upon admission;</p> <p><b><u>FINDINGS</u></b>  Resident #1, re-admitted on October 24, 2018, no admission assessment.</p>	<p><b>PART 2</b></p> <p><b><u>FUTURE PLAN</u></b></p> <p><b>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</b></p> <p><i>An assesment upon readmission will be conducted / completed in accordance with ARCA Re-admission Check List. [ OHCA form ARCA N LA, 01/07 ]</i></p>	<p>04.08.2019</p>

Licensee's/Administrator's Signature: \_\_\_\_\_

*Leandro Paranaíba*

Print Name: \_\_\_\_\_

*Leandro Paranaíba*

Date: \_\_\_\_\_

*04.08.2019*